

* This form applies only to the ARRA Premium Reduction *
FORM FOR SWITCHING COBRA BENEFIT OPTIONS

Instructions: To change the benefit option(s) for your COBRA continuation coverage to something different from what you had on the last day of employment, complete this form and return it to your former employer at the address listed below. **Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options. The effective date for the new coverage option will be the first of the month following receipt of this form.**

Send completed form to: [*insert Employer contact name and address*]

This form must be completed and returned by mail or hand-delivery no later than [*enter date*]. (If mailed, it must be postmarked by this date. If hand-delivered, it must be received at the address above by this date.)

***THIS IS NOT YOUR ELECTION NOTICE*
YOU ALSO MUST COMPLETE AND RETURN THE COBRA NOTICE OF ELECTION FORM TO
SECURE YOUR COBRA CONTINUATION COVERAGE.**

I (We) would like to change the COBRA continuation coverage option(s) in the State of South Carolina Employee Insurance Program (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____			
Old Coverage Option: _____			
New Coverage Option: _____			
b. _____			
Old Coverage Option: _____			
New Coverage Option: _____			
c. _____			
Old Coverage Option: _____			
New Coverage Option: _____			

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

Signature of employer responsible for COBRA administration for the Plan under ARRA

Date

Group ID#